Public Disclosure Authorized

Public Disclosure Authorized

Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 10-Apr-2020 | Report No: PIDA29104

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Marshall Islands	P173887	RMI COVID-19 Emergency Response Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	10-Apr-2020	24-Apr-2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	The Republic of the Marshall Islands	Ministry of Health and Human Services	

Proposed Development Objective(s)

To prevent and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in the Republic of the Marshall Islands.

Components

Component 1. Emergency COVID-19 Response
Component 2. Implementation Management and Monitoring and Evaluation

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	2.50
Total Financing	2.50
of which IBRD/IDA	2.50
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	2.50
IDA Grant	2.50

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Program Context

1. **An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China. Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled.** On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spread across the world. As of April 9,WHO data shows the outbreak has resulted in 1,439,516 confirmed cases, 85,711 confirmed deaths covering 212 countries. The epicenter of the outbreak shifted from China to Europe and USA in end March 2020.

2. COVID-19 is one of several emerging infectious diseases (EID) outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts. The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavior risk factors such as tobacco use and pre-existing chronic health problems that make viral respiratory infections particularly dangerous.

3. **This project information document describes the emergency response to the Republic of the Marshall Islands (RMI) under the COVID-19 Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA),by the World Bank's Board of Executive Directors on April 2, 2020 (PCBASIC0219761) with an overall Program financing envelope of up to US$6 billion.**

4. **The project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FCTF).** The proposed project will help ensure adequate resources to fund a rapid emergency response to COVID-19. The SPRP is aligned with WBG strategic priorities, particularly the WBG's mission to end extreme poverty and boost shared prosperity. The MPA with its focus on preparedness, grounded in a multi-sector public health approach, is also critical to achieving Universal Health Coverage. It is also aligned with the WBG's support for national plans and global commitments to strengthen pandemic preparedness through three key actions: (i) improving national preparedness plans including organizational structure of the government; (ii) promoting adherence to the International Health Regulations (IHR); and (iii) utilizing an international framework for monitoring and evaluation (M&E) of IHR.

Country Context

5. **The RMI is one of the world's smallest, most isolated, and vulnerable nations.** The country consists of 29 atolls and 5 isolated islands (24 of which are inhabited) and has a total land mass of just 181 km² set in an area

of over 1.9 million km^2 in the Pacific Ocean. The population of the RMI is estimated at 53,066[1], of which the two largest urban centers, Majuro (the nation's capital) and Ebeye, have populations of 28,000 and 9,614, respectively. The RMI was consolidated into the Trust Territory of the Pacific Islands governed by the United States (US) during the Second World War. It became self-governing in 1979 and achieved formal independence in 1986.

6. **The RMI faces many of the development challenges common to small, remote economies with dispersed populations.** Small size and remoteness increase the costs of economic activity and make it difficult to achieve economies of scale. Remoteness also imposes transport costs that increase the costs of trade and fundamentally constrain competitiveness of exports of goods and services in world markets. These same factors also increase the cost and complexity of providing public services.

7. **The RMI is a sovereign nation in a "Compact of Free Association" (CFA) agreement with the United States.** The first CFA was signed in 1983 and continued through 2003. An amended CFA became effective on May 1, 2004, providing approximately US$70 million in grants per year through the Compact Sector Grants (CSGs). With substantial constraints to export-led growth, the Marshall Islands is heavily dependent on aid and other fiscal transfers. The current account deficit is largely financed by grant inflows. Aid and fiscal transfers, primarily from the US, support reasonable—though declining—standards of living for most of the population.

Sectoral and Institutional Context

8. **While health outcomes have improved slowly over time, the RMI continues to face the double burden of communicable and non-communicable diseases (NCDs), while significant ongoing challenges remain with maternal, newborn health and nutrition.** Cardiovascular disease and diabetes accounted for two-thirds of deaths in 2017[2], and over 20 percent of adults had diabetes in 2016.[3] Tuberculosis (TB) is also a leading cause of death, and the country has reported multi-drug resistant TB. In recent years, RMI has also had to respond to infectious disease outbreaks and threats including Zika virus, dengue fever, and measles. These diseases have been shown to increase vulnerability to severe COVID-19 (and other infections), therefore putting the population of the RMI at high risk should COVID-19 reach the country. This is exacerbated by crowded housing and densely populated urban settings, which further increase the risk for transmission of infectious diseases.[4]

9. **To date, the RMI remains one among the less than twenty countries without a confirmed COVID-19 case but the government has determined that there is a "moderate to high risk" for COVID-19 to affect RMI due to usually frequent travel between RMI and affected areas such as US, Hong Kong, Singapore, Japan, etc.** There are also quarantine compliance issues at entry points and seaports. The remoteness of the RMI has bought the country time in preventing a COVID-19 outbreak, but the prevention strategies deployed present transport and logistics challenges to preparedness and response. From 8 March 2020, the RMI prohibited all international arrivals by land and sea, including for Marshallese citizens abroad. As with the rest of the Pacific, travel restrictions in RMI have resulted in the suspension of nearly all commercial air transport.

[1] RMI Government Statistics Office projections based on the 2011 RMI Census
[2] http://www.healthdata.org/marshall-islands
[3] WHO. 2016. Diabetes country profiles. Available: https://www.who.int/diabetes/country-profiles/mhl_en.pdf?ua=1
[4] Overcrowding and limited housing are serious problems on Ebeye – an atoll less than one mile long and home to nearly 10,000 residents. A typical Ebeye household consists of several families living together in one overcrowded, aging, single-story wooden structure. Some households have their family members sleep in shifts as there are no adequate floor space for all its members.

10. **A COVID-19 outbreak would place considerable constraints on an already under-resourced health care system.** There is very limited tertiary care capacity in the RMI, in part because of the size of the population, but also due to capacity challenges, and patients requiring advanced tertiary care are referred overseas. However, current travel restrictions limit this as an option. Health services are delivered in two hospitals (in Majuro and Ebeye) and 56 public health centers/dispensaries[5] (primarily located on the outer islands (OIs)). There are 108 hospital beds in Majuro, of which three are intensive care unit (ICU) beds. MOHHS faces a number of health workforce challenges, including (i) suboptimal availability and distribution of human resources (there are no respiratory technicians on Ebeye, and limited nursing staff in both Majuro and Ebeye); (ii) limited communication across health facilities programs and providers; and (iii) insufficient staff training, supervision, and performance management.

11. **The Government of RMI (GORMI) has mobilized its National Disaster Committee (NDC) to take the lead with preparedness and response to a potential COVID-19 outbreak.** The National Disaster Management Office (NDMO) in the Office of the Chief Secretary has activated the National Emergency Operations Center (NEOC) and its technical clusters (Water sanitation and hygiene, health, logistics, infrastructure and other relevant agencies) to provide coordination and implementation advice on COVID-19. Routine support from US Federal Grants to the Preparedness and Surveillance Departments in MOHHS have enabled the country to sustain a minimal level of health preparedness and rapidly mobilize the EOC, initiate multisectoral communication, and begin trainings. However, the MOHHS recently conducted a preparedness self-assessment in late March 2020 and scored at 57/100, largely due to the absence of human resources, personal protective equipment (PPEs) and other infection prevention and control (IPC) supplies, and laboratory capacity.

12. **The RMI CORONAVIRUS (COVID-19) Pandemic Preparedness and Response Plan outlines priority actions across sectors to strengthen the preparedness in RMI to rapidly detect and respond to the potential introduction of COVID-19.** The NDC and Ministry of Finance (MOF) are seeking financial support for the Plan.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To prevent and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in the Republic of the Marshall Islands

Key Results

13. **The achievement of the PDO will be monitored through the following PDO level outcome indicators:**
    - Number of community non-pharmaceutical COVID-19 containment strategies deployed
    - Number of suspected cases of COVID-19 reported and investigated as per MOHHS protocol
    - Number of staff trained in infection prevention and control per MOHHS protocol

[5] Outer Island dispensaries are staffed by a para-professional health assistant (high school graduates who receive an intensive 18-month core curriculum, covering English, basic anatomy and pathophysiology, and basic pharmacology). Dispensaries are often without electricity and have limited stocks of equipment and pharmaceuticals. They are often equipped only to provide emergency first aid.

D. Project Description

14. The PDO will be achieved through two components: (i) Emergency COVID-19 Response; and (ii) Implementation Management and Monitoring and Evaluation.

Component 1. Emergency COVID-19 Response (US$2.10 million)

15. This component will provide immediate support to RMI to prevent COVID-19 from arriving, limit local transmission, and equip the health system to simultaneously respond to the outbreak and sustain routine services. The component will include two sub-components.

Sub-component 1.1: Prevention and Surveillance: Communication, Physical Distancing, Case Detection, Confirmation, and Contact Tracing (US$0.465m)

16. This sub-component will provide support to RMI to enhance disease prevention measures and strengthen core epidemiological functions with the aim to prevent, mitigate, and control the impact of COVID-19 on the Marshallese population and prepare the country for future public health emergencies. It will finance activities including: supporting disease prevention efforts, and developing and implementing strategies, focused on communication, behavior change and physical distancing for COVID-19. It will also finance strengthening of core epidemiological functions to respond to COVID-19 and future public health emergencies, such as: case detection, laboratory confirmation, contact tracing, recording, and reporting.

Sub-component 1.2: Strengthening health service delivery to respond to COVID-19 (US$1.635m)

17. This sub-component aims to strengthen the RMI's health care system to plan for and provide optimal service delivery and case management for COVID-19 patients, while maintaining essential health services and minimizing infection risks for health personnel and patients. The sub-component will finance the costs of equipping health facilities on Majuro and Ebeye to manage COVID-19 cases and sustain routine health service delivery, through: (i) clinical surge support to add provider capacity; (ii) trainings, coaching, and backstopping (on-site or virtual) for existing health professionals; and (iii) procurement of medical equipment, commodities, and supplies for COVID-19 case management. The sub-component will also finance activities aimed at minimizing the risk of infection in health facilities for providers and patients, such as: (i) appropriately targeted risk communication and IPC training and monitoring for health providers; (ii) supplies and consumables (PPE, IPC consumables, hand sanitizer); (iii) minor facility upgrading to enhance IPC in health facilities (handwashing, ventilation) to ensure adherence to standards; and (iv) minor health care waste management upgrading (as necessary).

Component 2: Implementation Management and Monitoring and Evaluation (US$0.4 million)

18. This component will provide technical, operational and administrative assistance to the GORMI on all aspects of project management and implementation, including relevant monitoring and evaluation activities.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

19. **The project will have long term positive environmental and social impacts, insofar as it should improve COVID-19 prevention, mitigation, monitoring and control and develop systems for future public health emergencies.** Nevertheless, in the short-term the environmental risks are considered substantial.

20. **The main environmental risks identified are:** (i) the occupational health and safety issues related to testing and handling of supplies and the possibility that they are not safely used by laboratory technicians and medical crews; (ii) the occupational health and safety (OHS) issues for medical staff and employees related to the treatment of COVID-19 patients (if an outbreak were to occur); and (iii) medical waste management and community health and safety issues related to the handling, transportation and disposal of hazardous and infectious healthcare waste. As no civil works other than minor upgrading of laboratories and health facilities on government leased sites are to be undertaken, environmental risks associated with these works are expected to be minor and readily mitigated.

21. **The social risks are considered substantial.** While some social risks and impacts are substantial, they are considered temporary, predictable, and readily managed through project design features and mitigation measures. No land acquisition or involuntary resettlement impacts are expected. The project will include the upgrading of existing facilities in the urban centers of Ebeye and Majuro. No new land will be acquired or accessed. The key risks relate to (i) inequitable access to project supported facilities and services, particularly for vulnerable and high-risk social groups including poor, disabled, elderly, isolated groups, (ii) increased gender-based violence (GBV), including sexual exploitation, abuse and harassment (SEA/SH) as a result of physical distancing strategies, (iii) inadequate infection management procedures, resulting in virus transmission among healthcare workers and the public, and (iv) insufficient public health and safety information, exacerbating virus transmission among community members.

22. **To mitigate the above-mentioned risks, an Environmental and Social Management Framework (ESMF) will be prepared during project implementation and no later than 30 days after the effective date of the financing agreement.** This will include environmental and social mitigation measures to be implemented for the various proposed activities. The ESMF will contain an Infection Prevention and Control and Waste Management Plan (IPC&WMP), Updated Stakeholder Engagement Plan (SEP, including a GM) and Labor Management Procedures (LMP). Implementation of these documents is included in the Environment and Social Commitment Plan (ESCP) which will also include the Project’s agreed material measures, timeframe and responsibilities.

23. **The ESMF will be prepared in line with the applicable Environmental and Social Standards (ESS) of the WB’s Environment and Social Framework (ESF) and the WHO COVID-19 guidance tools and other good international industry practice (GIIP).** The ESMF will elaborate on the roles and responsibilities for ESF planning,

implementation and monitoring, training requirements, the timing of implementation milestones and budgets. Procurement of goods (purchase of testing kits, medical equipment, PPE etc.) can be initiated as soon as the project is approved but deployment of medical supplies and equipment can only occur after the ESMF and IPC&WMP are in place and training provided.

24. **Project implementation will be the responsibility of the Project Director and Project Administrators from MOHHS, who will carry out day-to-day project management and implementation.** The Project Director will be supported by the Central Implementation Unit (CIU) who will provide environmental and social risk management expertise to the Project. The CIU currently has two experienced safeguards specialists, one international and one national staff. The CIU safeguards staff have been satisfactorily preparing and implementing World Bank safeguards instruments and monitoring environmental and social risks across the World Bank portfolio for over 18 months. These specialists are trained in the ESF and have implemented the ESF on two projects to date. The CIU is in the process of recruiting a full time social specialist who will provide additional support to the Portfolio and this Project. The additional social specialist is anticipated to start in June 2020. The team has the capability and capacity to support MOHHS with ESF compliance.

E. Implementation

Institutional and Implementation Arrangements

25. **The MOHHS will be the project's implementing agency and will have the overall implementation responsibility for the Project,** including the responsibility for carrying out day-to-day management and implementation of the project and coordinating with other government ministries/agencies and stakeholders on all aspects of project implementation as required. Given the limited scope and short duration of the project, and that the project is an integral part of the MOHHS COVID-19 response plan, a separate PIU will not be established. The MOHHS will nominate a Project Director at the Deputy Secretary / Assistant Secretary level to lead project management and implementation. The Project Director will be directly supported by a project administrator. This will ensure that project implementation is expedited through involvement of government officials at the decision-making level given the emergency needs.

26. **The Project Director and project administrator will be supported by the Central Implementation Unit (CIU).** The CIU is a unit housed within the Division of International Development Association under MOF. The CIU provides centrally housed expertise for functions that cut across the World Bank portfolio implementation activities including environmental and social, financial management and procurement functions.

27. **The National Disaster Committee (NDC), chaired by the Chief Secretary (National Disaster Controller, or NDC-CS) will serve as the project steering committee (PSC).** The (NDC) will provide the oversight and guidance for project implementation. The key responsibilities of the NDC serving as the PSC are as follows: ensure the delivery of the project's outputs and the attainments of outcomes by facilitating coordination, as necessary, amongst the Line Ministries and Institutions participating in the NDC and by addressing coordination issues as they arise during the implementation of the project; review project reports as submitted by the Project Director and make decision thereon; and assess all policy-related issues and provide guidance as needed.

28. **A Project Operations Manual (POM) will be developed and adopted by MOHHS by not later than three months after the effective date of the Financing Agreement**. The POM will describe the arrangement and procedures for the implementation of the project, such as operational systems and procedures, project institutional arrangements, budgeting, auditing, finance and accounting procedures (including funds flow and

disbursement arrangements), procurement procedures, project monitoring, reporting, evaluation and communication arrangements, personal data collection and processing, and implementation arrangements for the Environmental and Social Commitment Plan (ESCP) as well as the preparation and/or implementation of instruments referred to in the ESCP as per World Bank ESF guidance. The POM will reflect mitigation measures proportionate to the risks of implementing an emergency operation in RMI such as fiduciary controls and transparency.

CONTACT POINT

World Bank

Anne Marie Provo
Nutrition Specialist

Annette Gaye Leith
Senior Operations Officer

Borrower/Client/Recipient

The Republic of the Marshall Islands

Implementing Agencies

Ministry of Health and Human Services
Jack Niedenthal
Secretary
sechhs.rmi@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Anne Marie Provo Annette Gaye Leith

Approved By

Environmental and Social Standards Advisor:		
Practice Manager/Manager:		
Country Director:	Mona Sur	10-Apr-2020